# Response to OFCO 2003 Annual Report

## Response to the Ombudsman's Systemic Recommendations

In addition to responding to specific complaints, the Ombudsman is statutorily charged with developing recommendations for improving the state child protection and child welfare system. This section briefly presents the recommendations included in the Ombudsman's 2003 Annual Report and the Children's Administration's Responses to those recommendations.

This section also briefly describes the response by the Legislature to the Ombudsman's concerns about adolescents, ESB 5583; and chronic neglect, ESSB 5922; both signed into law in 2005.

## The 2003 Office of the Family & Children's Annual Report

In the 2003 Annual Report, the Ombudsman reported on its review of the Rafael Gomez fatality. The report detailed the key issues that the Ombudsman had asked the Community Fatality Review Team convened by DCFS to address. Second, the Ombudsman reviewed the use of Child Protection Teams (CPTs), including findings and recommendations because of reports about the inconsistent use of CPTs. Finally, the Ombudsman recommended improvements in four other child welfare/child protection areas: evidence-based assessment and treatment; protecting adolescents; children with developmental disabilities; and relative and kinship care.

### THE RAFAEL GOMEZ FATALITY

#### *Ombudsman Issues*

The Ombudsman asked the DCFS-convened Community Fatality Review Team studying the death of Rafael Gomez to address the following seven issues:

1. **Screening and Investigation** – Rafael received several injuries while in his parents' care. Case records indicated that CPS did not investigate reports of these injuries.
2. **Risk Assessment** – Instead of assessing the parents' risk for physical abuse, the worker obtained a "psycho-social" evaluation of both parents.
3. **Child Protection Team** – The DCFS worker failed to provide the CPT with complete information, such as medical reports of all of the child's injuries and other reports of maltreatment.
4. **Support Services** – The CWS worker did not ensure that critical in-home services, such as a public health nurse were in place.
5. **Non-compliance –** No evidence that DCFS worker's support for the mother was shaken despite her lack of compliance with substance abuse treatments.
6. **CPT Staffings** – Asked review team to consider how CPT could be more effective.
7. **In-home Service Providers** – Asked review team whether Family Preservation Service and Home Support Service providers were sufficiently equipped to address issues identified in psycho-social evaluation of Rafael's parents.

### *Children's Administration Responses*

In August 2004, Children's Administration (CA) produced a comprehensive report responding to each recommendation made by the DCFS-convened Fatality Review Team. This report included descriptions of actions CA had already taken, actions CA planned to take, and CA's timelines for completion. Children's Administration then updated this report in January 2005. Although these reports were not created to directly respond to the Ombudsman, the responses adequately covered the Ombudsman's concerns.

As of January 2005, CA stated that the agency had fully completed 4 recommendations:

- CA had made the Fatality report available to employees and stakeholders in English and Spanish;
- CA had compiled a comprehensive list of responses to each recommendation;
- CA had provided additional training to workers and supervisors in Moses Lake and had made several modifications in the Academy training; and
- CA already had a policy in place that social workers should not carry cases until they had received basic training and that when they changed positions they received training.

As of January 2005, these were the only 4 completed recommendations. CA stated that 7 other recommendations were partially completed, 20 recommendations were in the process, and 6 were of an ongoing nature.

## CHILD PROTECTION TEAMS (CPTS)

### *Ombudsman Recommendations*

Second, the Ombudsman reviewed DCFS use of Child Protection Teams. Based on this review, the Ombudsman offered five recommendations:

1. **Clarify policy and practice guidelines for CPTs** – Although CA policy does contain some guidelines, they are too ambiguous leaving room for wide interpretation. The Ombudsman suggested that the CA define more clearly when a CPT is required, what should be the membership of the team.

2. **Create a system of accountability for following CPT policy** – There is no system to ensure that DCFS holds a CPT review in all case in which the policy requires a CPT, such as an information system to track compliance and report CPT results. At a minimum, DCFS should be required to document whether a CPT is required in the CAMIS-GUI information management system.

3. **Require training of DCFS staff** – Workers need to be trained on the value of the CPT as well as on how to provide full and accurate information for a CPT.

4. **Provide support, authority, sufficient time and specialized training for CPT coordinators/ facilitators** – CPT coordinators must be trained to be effective.

5. **Require orientation and training for all volunteer CPT members** – At the time, CPT volunteers were not required to receive training.

***Children's Administration Response*** *(responses are taken verbatim from a CA report from Jan. 2005)*[1]

- The Gomez Child Fatality Review Team report reflected the Ombudsman's concerns related to Child Protection Teams, and made detailed recommendations to review and revise the CPT program.
- The CA fully supports these recommendations and has included the strengthening and improvement of CPTs within its Kids Come First II comprehensive reform plan (KCF II: Safety 4.4).
- A multi-disciplinary team has been established to review the CPT program and will report its recommendation to CA management in April 2005.
- Based on these recommendations, CA will:
    - Clarify policies and practice guidelines;
    - Develop a revised CPT handbook for CA staff and CPT members;
    - Provide training to CPT members and CA staff;
    - Clarify the role of CPT coordinators; and
    - Provide ongoing support to CPTs.

In May 2005, CA and its CPT workgroup produced a draft of the Practice Guidelines for "Child Protective Teams." The Ombudsman has not received additional information from CA that this draft has been finalized and implemented.

## EVIDENCE-BASED ASSESSMENT AND TREATMENT

***Ombudsman Recommendation***

Direct the Washington State Institute for Public Policy (WSIPP) or other entity to convene a multidisciplinary summit to examine effective models of assessment and treatment and make recommendations to DSHS.

***Children's Administration Response*** *(responses are taken verbatim from a CA report from Jan. 2005)*

- CA is committed through a process of collaboration with providers, academics, clinicians, and child welfare experts:
    - To expand the menu of evidence based services available to children and families; and
    - To identify and address infrastructure issues.
- CA will participate in every opportunity to expand and implement evidence-based practices in child welfare services.
- CA intends to increase services available to clients in the three child welfare/home visitation programs identified by the recent WSIPP study:

[1] Children's Administration Response to the 2003 Annual Report of the Office of Family and Children's Ombudsman.

- Nurse-family partnership for low income women
- Home visiting programs for at-risk mothers and children
- Parent-child interaction therapy

- CA is pursuing additional efforts to support and implement evidence based practice:
  - Piloting Multi-systemic Therapy and Functional Family Therapy in two regions
  - CA intends to implement the Child Abuse Potential Assessment to assess the risk of a caregiver physically abusing a child
  - Initiating proposals to implement models of evidence-based therapeutic foster homes
  - Participating in the Children's Mental Health Workgroup to establish evidence-based child mental health services
  - Providing support to increase access to Early Childhood Education and Assistance;
  - Implementing Contract Outcome Initiative to measure effectiveness of all contracted services.

## PROTECTING ADOLESCENTS

### *Ombudsman Recommendation*

Amend state law to clarify that DSHS may not refuse to provide adolescents with child protective services based on their age.

### *Legislative Response*

In the Final Bill Report of Engrossed Senate Bill 5583, the Senate noted that the Ombudsman's 2003 Annual Report noted that the Ombudsman had received complaints that referrals to the Children's Protective Services (CPS) were often screened out or assigned a lower standard of investigation based on the child's age, on the assumption that an adolescent is able to protect himself or herself. Effective July 2005, the Legislature passed a bill "[r]equiring training of children's administration employees concerning older children who are victims of abuse or neglect."

On December 30, 2005, DSHS CA submitted to OFCO a draft of a proposed curriculum entitled "Best Practice in Screening & Assessing Needs for Adolescents" in response to ESB 5583. As required by the law, the proposed curriculum currently includes:

- A review of the relevant laws and regulations related to the screening, assessing and investigation of referrals of CA/N made involving adolescents.
- A review of screening procedures of allegations made related to adolescents with case scenarios and discussion of best practice.
- A review of safety assessment and risk assessment models related to work with adolescents with case scenarios and discussion of best practice.

The Ombudsman reviewed and commented on the proposed curriculum to ensure that it addressed the concerns identified by OFCO in the 2003 Annual Report and the requirements of the law.

***Children's Administration Response*** *(responses are taken verbatim from a CA report from Jan. 2005)*

- CA policy requires all abuse/neglect referrals to be assessed and screened on the basis of risk and not age;
- The CA safety assessment and risk assessment models were reviewed in 2002 to eliminate age as a risk factor;
- CA will strengthen its policy to ensure that adolescents receive CPS services based on their circumstances and not on their age (June 2005);
- CA will provide additional and regular training to CA intake staff related to the screening and response to CPS referrals involving adolescents (February – June 2005 and ongoing);
- CA will implement regular training on safety and risk assessment for all staff. Assessing adolescents safety and risk will be included in this training (February – June 2005);
- CA will implement a new 3-day CPS investigation-training program. The training will include investigation of abuse/neglect referrals related to adolescents (February 2005); and
- CW will review CPS screening decisions related to adolescents on a quarterly basis (April, July, October 2005).

## CHILDREN WITH DISABILITIES

***Ombudsman's Recommendations***

- Require DSHS to provide an adequate supply and range of residential placement options for children with developmental disabilities or other serious handicaps;
- Require DSHS to develop and implement a coordinated protocol between case worker, Division of Developmental Disabilities (DDD), and mental health services to address placement and service needs of families with developmentally disabled children and children with serious handicaps; and
- Require DSHS to submit to the Legislature a report setting forth protocol to coordinate placement and services for these children.

***Children's Administration Response*** *(responses are taken verbatim from a CA report from Jan. 2005)*

- DDD continues to have statutory authority for services to children with developmental disabilities. The DDD Voluntary Placement Program was capped due to budgetary concerns;
- DDD & CA have implemented an Intra-Agency Agreement for providing services jointly to children with acute needs using existing funds;
- To date 25 children have been placed through this agreement. Most of these children are not IV-E eligible and placement is supported through state funds;

- To date, CA has committed $1.5 million annually to support these placements;
- DDD has submitted a decision package requesting funds for 24 new placements;
- CA is in the process of implementing new performance based contracts for the recruitment of foster homes based on regional needs assessment and resource management plans;
- CA has completed regional service agreements with regional support networks (RSNs) to improve access to children's mental health services for children served by CA, including children with developmental disabilities; and
- CA, Mental Health Division (MHD), and Juvenile Rehabilitation Administration (JRA) are collaborating to develop an improved system for children's mental health services.

## RELATIVE AND KINSHIP CARE

***Ombudsman Recommendations***

- As part of its improvement activities, Children's Administration should develop:
    - A statewide protocol for identifying relative/kinship placement resources;
    - An objective assessment process for evaluating the suitability of relative/kinship placement decisions;
    - Criteria to assist workers in making relative/kinship placement decisions; and
    - A process for promoting family involvement in the agency's case planning process.

***Children's Administration Response*** *(responses are taken verbatim from a CA report from Jan. 2005)*

- CA has developed a new *Practices and Procedures Guide* for relative search and placement. This *Guide* will be implemented in March 2005 and outlines:
    - When relative searches are required; and
    - When activities constitute an adequate search.
- A new relative home assessment tool is in development and is scheduled for implementation June 2005. This will result in all licensed caregivers, including kinship care providers, receiving the same quality of assessments.
- The *Practices and Procedure Guide* includes criteria to guide placement decision-making.
- Kids Come First II has a strong emphasis on family involvement in the case planning process including:
    - New policies, practice guide and training to strengthen the requirement that families be involved the case planning and decision making (October 2005);
    - Development of a strength-based family assessment tool (June 2005);
    - Implementing Family Team Decision Making model

## The 1999 & 2000 Office of the Family & Children's Ombudsman Annual Reports and the Justice and Raiden Robinson Fatalities Review Report by the Family and Children's Ombudsman

### *Ombudsman Recommendation*

In the 1999 Annual Report, the Ombudsman identified as an area of concern the lack of timely and appropriate intervention in chronic child neglect cases. By the 2000 Annual Report, the Ombudsman recommended that the Legislature "[m]odify the statutory definition of neglect by deleting the reference to 'clear and present' danger and clarifying that neglect may result from 'a pattern of conduct.'" This change in definition would permit a court to consider cumulative harm to a child in determining whether the child is dependent.

And then, once again in 2005, in the Report for the Review of the Justice and Raiden Robinson Fatalities, the Ombudsman called for the Legislature to "[m]odify the statutory definition of child abuse and neglect and allow CPS to intervene earlier in an investigation to protect children at risk of abuse or neglect." The deaths of these two children gave a tragic illustration of the need for a change in the law.

### *Legislative Action*

In 2005, the Legislature passed the Justice and Raiden Act (Engrossed Substitute Senate Bill 5922), which will take effect on January 1, 2007 and change the definition of "abuse or neglect" and "negligent treatment or maltreatment" of a child to include language pertaining to chronic neglect for the purposes of an investigation of child abuse or neglect; permit the Department of Social and Health Services (DSHS) to offer voluntary services to a parent to correct the deficiencies that placed the child at risk for child abuse or neglect; and permit the DSHS to file a dependency petition if a parent fails to comply with treatment to correct the deficiencies that placed the child at risk for child abuse or neglect.

## Continued Cooperation

The Ombudsman acknowledges and appreciates the effort of CA to keep the Ombudsman informed of CA's progress with regard to the Ombudsman's recommendations. Without such cooperation, the Ombudsman would have a difficult time tracking which recommendations have been accepted and accomplished, which recommendations have been accepted but not yet accomplished, and which recommendations have been rejected. The Ombudsman looks forward to continued cooperation with CA working in the best interest of the children of the state of Washington.